Please send referrals via email to: information@thevillageict.com or fax to (316) 221 7139

THE VILLAGE

Referral Form

Date of Referral: _____ **Referred By:** _____

Patient Name: _____ **Date of Birth**: _____

Street Address: _____ **Apt**: _____

City: _____ **Zip**: _____

Phone: _____

Email: _____

Insurance (Please Include Primary and Secondary): _____

Primary Language: English Spanish Other

Secondary Language: English Spanish Other

Which best describes the Patient's Circumstances (please circle)?

Pregnant Postpartum Miscarriage/Pregnancy loss Infant loss Infertility Eating Disorder

Symptoms of concern (Please circle)?

Anxiety Depression Grief Anger Trauma Suicidal thoughts

Thoughts to harm others Disordered Eating

Edinburgh Score (if completed):_____

Referring Provider:

Name:_____ Facility:_____

Phone Number: _____

Fax Number: _____

Address: _____

Notes/Comments: _____

Does the Patient Give Consent for Our Organization to contact her/him? yes / no

For Program Use Only

Date Received: _____*- (Circle one) Routine / Urgent*

Attempt to Contact #1

Attempt to Contact #2

Attempt to Contact #3